

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-020850

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 223 Primary Registration District No. 4339 Registrar's No. 27

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>MONROE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>MONROE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PARIS</u>		c. CITY OR TOWN <u>PARIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>S. MAIN ST.</u>		d. STREET ADDRESS (If outside, give location) <u>534 SOUTH MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH MORRIS WHITECOTTON</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>24</u> Year <u>1963</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20/1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
13a. FATHER'S NAME <u>JAMES H. WHITECOTTON</u>		13b. MOTHER'S MAIDEN NAME <u>ZORA A. WILSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		17. INFORMANT <u>DAVID M. PROCTOR JR.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fans &amp; death in home</u> DUE TO (b) <u>Franklin Cunningham</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <u>8:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>Dr. M. E. Agnew</u>		22c. DATE SIGNED <u>5/25/1963</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MAY 27, 1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE CEM.</u>		23d. LOCATION (City, town, or county) <u>PARIS, Mo.</u>	
24. FUNERAL DIRECTOR <u>E.H. AGNEW</u>		25. DATE RECD. BY LOCAL REG. <u>5-25-63</u>	
26. REGISTRAR'S SIGNATURE <u>J. L. Darnell</u>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 5 1963

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*Robert E. Wood*

Licensed Embalmer No. 5205

P. O. Address Paris, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.